



LIGHTHOUSE
D E N T A L

Records Release Form

Date: _____

Patient's name(s): _____

DOB: _____

Address: _____

Phone: _____

This is a request to release my dental records from the office of:

Email/Mail records to:

Lighthouse Dental

2471 Delaney Ave

Wilmington, NC 28403

INFO@LIGHTHOUSEEDENTALNC.com

Thank you for your attention to this matter.

Patient's Signature

P: 910.762.3481 INFO@LIGHTHOUSEEDENTALNC.COM 2471 DELANEY AVENUE | WILMINGTON, NC 28403

LIGHTHOUSEEDENTALNC.COM